Cert.	Issued
Certificate Mailed	

APPLICATION FOR LICENSE TO PRACTICE RESPIRATORY THERAPY

South Dakota State Board of Medical and Osteopathic Examiners
125 S. Main Ave. • Sioux Falls, SD 57104

All applicants for licensure must submit one photograph with the application.
Answer all questions. If answer is "no" or "none," so state.
Please type or print clearly in ink.
If additional space is required, attach separate sheets, indicating section to which they refer.

Social Security # _____

Compliance with the Board's request for your Social Security number is **Voluntary**. The use that the Board will make of such Social Security number is the reporting of possible disciplinary actions. The Board's authority to make this request is its inherent authority to regulate respiratory care practitioner licensure.

Applications must be accompanied by applicable fees. Fees are non-refundable

Schedule of Fees:	Endorsement	$75
	Temporary Permit	$40

Name _____
Last First Middle Sex Birthdate

Address _____ Citizenship _____

_____ Birthplace _____

Telephone number ( ) _____

Name of Supervising Physician _____

Application if made for licensure by

A. Endorsement ( )
B. Temporary Permit ( )

Height: _____ Weight: _____

Color of Eyes: _____ Color of Hair: _____

Distinguishing Mark (if any): _____

(PICTURE)

I certify that the attached photograph is a true likeness of myself. Enter date taken on photograph (within the past 5 years) and sign in ink across the bottom.

TO BE COMPLETED BY APPLICANT UNDER OATH

1. TRAINING AND EXPERIENCE

List in chronological order all respiratory therapy education and experience, including college and/or university, and practice. Include **ALL** periods of time from the date of graduation from your training program to the present, whether or not engaged in activities related to respiratory therapy.

From Month, Day Year	To Month, Day Year	Name and Location of Institution Place of Education or Practice	Degree or Certificate Date Received, or Nature of Experience

2. LICENSURE

List all licenses applied for or held, currently or in the past.

3. **PERSONAL DATA**

If any of the following questions are answered "Yes" full details must be furnished on a separate sheet and attached, and shall be considered as part of this application.

Have you ever:	**Yes**	**No**
1. Had a license canceled, limited, suspended, or revoked?	( )	( )
2. Been subject to proceedings by a licensing agency to cancel, limit, suspend, or revoke a license?	( )	( )
3. Been denied licensure in another state?	( )	( )
4. Been convicted, or is there now pending any criminal prosecution against you which would constitute a felony, involve your respiratory care practice or involve moral turpitude?	( )	( )
5. Had your hospitalization privileges revoked, reduced or otherwise restricted?	( )	( )
6. Been requested to appear, or appeared, before any licensure board concerning any violation by you of any law, rule or regulation or any state, district, territory or province of the United States or Canada?	( )	( )
7. Been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	( )	( )
8. Been notified of a complaint by a medical facility, professional society or association, or any licensing agency?	( )	( )
9. Settled a civil damages action, by the payment of money or otherwise, or had a civil judgment rendered against you involving malpractice or your practice as a respiratory therapist?	( )	( )
10. In the last five (5) years, have you:		
a. Been treated, hospitalized, or confined for:		
1. Alcoholism or alcohol abuse?	( )	( )
2. Drug use?	( )	( )
3. Mental illness?	( )	( )

If you answered "YES" to questions 1 through 10 above, provide specific information: _____

_____

_____

_____

AFFIDAVIT

I, _____, being first duly sworn depose and say that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of South Dakota; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in South Dakota.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as a respiratory therapist in the State of South Dakota.

_____

Signature of Applicant

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Notary Public

(SEAL)

My Commission expires: _____